RECORD OF CONSENT
FOR NON-SURGICAL PERIODONTAL TREATMENT

I understand that I have periodontal (gum and oral bone) disease. This disease and its process has been explained to me and I understand that it is caused by bacteria. I realise that this disease may be painless and asymptomatic, but that usually symptoms such as bleeding, swelling or recession of the gums, loose teeth, the appearance elongated teeth, bad breath, sensitivity and soreness may be noticed.

Treatment of periodontal disease may include periodontal scaling and root debridement (cleaning) either as a therapeutic procedure or preliminary to more extensive treatment. Periodontal scaling and root debridement aim to remove the calculus, bacterial plaque, bacterial toxins and some of the diseased tissue from the tooth surface and crevice around the tooth.

I understand:

- The purpose and benefit of this procedure is to reduce some of the causes of periodontal disease to a level more manageable by my own immune system
- My own efforts with home care are just as important as my professional treatment
- Some of the conditions caused by periodontal disease are irreversible
- Maintaining regular professional periodontal cleaning is essential
- Future re-treatment of scaling and root cleaning may be necessary

The consequences of doing nothing or discontinuing treatment may be, but are not limited to:

- Worsening of the disease, causing increased bone loss which may lead to teeth requiring extraction
- Increased infection, bleeding, pain and soreness
- Possible systemic problems - there are known and emerging links to: Heart disease, Stroke, Diabetes, Respiratory disease among others

The treatment risks may be, but are not limited to:

- Increased recession of the gum tissue and exposure of root surfaces as the tissue heals and swelling decreases
- Some pain, swelling or bruising may be experienced after treatment
- Increased sensitivity to hot, cold or sweet – this may require further treatment, may fade with time, or may persist no matter what is done

I understand the recommended treatment for my periodontal condition. Alternative treatment has been explained to me and the consequences of not receiving treatment.

Patient signature _________________________ Date____________________

Dentist signature _________________________ Date______